STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	(X3) DATE SURVEY		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETED	
155095		B. WING		03/22/2012		
		_		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R	2001 ⊦	IOBSON RD		
HERITA	GE PARK		FORT	WAYNE, IN 46805	<u> </u>	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	` `	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENC!)	DATE	
F0000						
	This visit was for Complaints IN0 IN00105276.	or the Investigation of 00105054 and	F0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion act.	ot s	
				provider of any conclusion set forth in the statement of		
	Complaints IN0	0105054 and IN00105276		deficiencies, or of any violation	n of	
	_	Federal/state deficiencies		regulation.This provider		
		legations are cited at		respectfully requests that the		
	F157, F514.			2567L Plan of Correction be considered the Letter of Credi	hle	
	1107,1011.			Allegation.Based on past surv		
	Survey dates: N	March 14, 15, 16, 22, 2012		history and no harm identified		
	Burvey dates. It	viaicii 14, 13, 10, 22, 2012		any resident; this facility		
	Facility number	000038		respectfully requests a desk		
	Provider number			review in lieu of a post-survey revisit on or after April 6, 2012		
	AIM number: 1			Teviole of of after 7 pm 6, 2012		
	Alivi liuliloet.	10022/4830				
	Survey team:					
	Ann Armey RN	T, TC				
	Carol Miller RN					
	(March 16 and 2	22, 2012)				
	Shelly Vice RN					
	(March 15, 2012					
		,				
	Census bed type	2:				
	SNF: 22					
	SNF/NF: 144					
	Total: 166					
	10001. 100					
	Census payor ty	me.				
	Medicare: 22	P**				
	Medicaid: 101					
	Other: 43					
	Total: 166					
	10tal. 100					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

TITLE

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/17/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO. LDING	NSTRUCTION 00	(X3) DATE ( COMPL		
		155095	A. BUI B. WIN			03/22/	2012
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
HERITAC	GE PARK				VAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Sample: 7						
		es reflect state findings ace with 410 IAC 16.2.					
	Quality review 3 Williams, RN	/23/12 by Suzanne					

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Event ID: YWD711

Facility ID: 000038

If continuation sheet

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/17/2012 FORM APPROVED OMB NO. 0938-0391

155095		A. BUILDING  B. WING			COMPLETED 03/22/2012		
	STREET ADDRESS, CITY, STATE, ZIP CODE				DDDESS CITY STATE 7ID CODE		-
NAME OF P	ROVIDER OR SUPPLIER				OBSON RD		
HERITAG	GE PARK				VAYNE, IN 46805		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0157	483.10(b)(11)						
SS=D	NOTIFY OF CHA						
	(INJURY/DECLIN	•					
	•	mediately inform the					
		with the resident's physician;					
		tify the resident's legal an interested family					
		ere is an accident involving					
		th results in injury and has					
		equiring physician					
	•	gnificant change in the					
	resident's physic	al, mental, or psychosocial					
	•	erioration in health, mental,					
		status in either life					
	threatening cond						
		need to alter treatment					
		a need to discontinue an					
	_	reatment due to adverse or to commence a new form					
	•	a decision to transfer or					
		sident from the facility as					
	specified in §483	•					
		also promptly notify the					
		nown, the resident's legal					
		interested family member					
	•	change in room or roommate					
		pecified in §483.15(e)(2); or					
		lent rights under Federal or					
		lations as specified in					
	paragraph (b)(1)	of this section.					
	The facility must	record and periodically					
		ess and phone number of the					
		epresentative or interested					
	family member.						
	Based on record	review and interview, the	F015	57	F-157 NOTIFICATION OF		04/06/2012
		ensure the resident's			CHANGESIt is the practice of t		
	-	tified timely in regard to			provider to ensure the physicia	ın,	
		oratory test which			legal representative or an		
		-			interested family member are notified when there is significal	nt .	
	indicated a need	ior treatment.			nouned when there is significal	IL	

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Event ID: YWD711

Facility ID: 000038

If continuation sheet Page 3 of 9

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLI			ETED	
		155095	B. WIN			03/22/2	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			OBSON RD		
HERITAG	GE PARK				WAYNE, IN 46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	· 	1	(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)			DATE
	This deficiency	affected 1 of 7 residents			change in the resident's physic	cal,	
	reviewed for abr	normal laboratory tests in			mental, or psyhosocial status.		
	a sample of 7 (R	•			However; based on the allege		
		esident B).			deficient practice- the following	9	
	F: 1: : 1 1				has been implemented:What		
	Findings include	);			corrective action(s) will be accomplished for those reside	nte	
					found to have been affected by		
	Resident B's reco	ord was reviewed on			the deficient practice:Resident		
	3/14/12 at 1:10 p	o.m., and indicated			B:The physcian was notified of		
	_	gnoses included, but were			the abnormal lab result and the		
	· `	npaired renal function			appropriate antibiotic was orde	ered	
	and urinary reter	•			and administered.How will you		
	and urmary reter	ition.			identify other residents having	the	
		1 1 10/5/40			potential to be affected by the		
		orders dated 3/7/12			same deficient practice and wi		
	indicated to obta	in a urine specimen for a			corrective action will be taken: other residents were found to	INO	
	urinalysis (U/A)	with a culture and			have been affected by the alle	ned	
	sensitivity (C/S)	if indicated.			deficient practice.Residents	gca	
					having abnormal lab value res	ults	
	The resident's nr	rogress notes dated 3/8/12			have the potential to be		
	_	cated a urine specimen			affected.The Nurse Managers		
	_				have been re-educated on		
	was sent to the la	aboratory.			obtaining lab results and ensu		
					the physician is notified timely		
		poratory test result dated			Education includes but is not limited to ordered labs being		
	3/10/12 at 06:31	(6:31 a.m.) indicated the			recorded on the Lab/X-Ray		
	resident had an u	urinary tract infection			Tracking Log upon receipt of the	he I	
	(UTI).				physicians order. The Tracking		
					Log is maintained by the Unit		
	The Physician's	Orders dated 3/12/12			Managers. The Unit Managers		
	1	er for Bactrim DS (an			check the log daily to ensure la	ab	
		*			results are received and the		
		t UTI) one tablet twice a			physician is notified timely of abnormal values based on		
	day for 7 days for a diagnosis of a UTI.				individual resident values. The	e	
	The Mediantian	Administration Record			Unit Managers check the lab fa		
					machine for lab results 2x/day		
	, ,	d the resident was started			and the Evening Nurse	tho	
	on Bactrim DS of	on 3/12/12.			Supervisor checks it 2x during	ине	

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Event ID: YWD711

Facility ID: 000038

If continuation sheet

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STATEME	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		a. Building		00	COMPLETED	
		155095	B. WIN			03/22/	2012
			Б. WПV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	CR.			OBSON RD		
HERITA	GE PARK				VAYNE, IN 46805		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	BROWDENG N. I.V. OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	I E	DATE
IAU	On 3/16/12 at 7 Nursing Service in regard to the notification, and #3 should have physician on 3/2 C/S laboratory in DNS indicated the exhibiting any sure UTI.  On 3/16/12 at 1 provided a late for 3/7/12, which physician had be history of VRE enterococci - base urine and wanted infection had residue.	2:15 a.m., the Director of the (DNS) was interviewed untimely physician of the DNS indicated LPN called the resident's 10/12 when the abnormal results were received. The the resident was not signs or symptoms of a 10:45 a.m., the DNS tentry on a Progress Note of the indicated the resident's (Vancomycin resistant acterial infection) in the old to make sure the solved.		1100	evening shift. The Weekend Nursing Supervisor checks the lab fax machine for lab results during the Weekend Supervisor 12 hour shift. Education provid March 27, 2012 by the Director Nursing Services. The facility is contracting with a different lab scheduled to begin providing service effective April 9, 2012. Director of Nursing Services is responsible to ensure compliance. What measures we be put into place or what syste changes you will make to ensure that the deficient practice does not recur: Residents having abnormal lab value results have the potential to be affected. The Nurse Managers have been re-educated on obtaining lab results and ensuring the physician is notified timely. Education includes but is not limited to ordered labs being recorded on the Lab/X-Ray Tracking Log upon receipt of the physicians order. The Tracking Log is maintained by the Unit Managers. The Unit Managers check the log daily to ensure laresults are received and the physician is notified timely of abnormal values based on individual resident values. The Unit Managers check the lab for machine for lab results 2x/day and the Evening Nurse Supervisor checks the lab fax machine for lab results are sults are received and the physician shift. The Weekend Nursing Supervisor checks the lab fax machine for lab results	4x or	DATE

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/17/2012 FORM APPROVED OMB NO. 0938-0391

	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155095		A. BUILDING  B. WING	00	COMPLETED 03/22/2012			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
HERITAG	SE PARK			OBSON RD WAYNE, IN 46805				
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
				during the Weekend Supervisor 12 hour shift. Education provide March 27, 2012 by the Director Nursing Services. The facility is contracting with a different lab scheduled to begin providing services April 9, 2012. The Director of Nursing Services is responsible to ensure compliance. How the corrective action(s) will be monitored to ensure the deficient practice who trecur: A CQI monitoring to titled "Lab Monitoring" will be utilized every week x 4, month 3 and quarterly thereafter for 6-months. Data will be submitted to the CQI committee. If 95% threshold is not met; an action plan will be developed. Non-compliance with facility procedure may result in disciplinary action up to and including termination.	led r of s  vill bl ly x ed			

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Event ID: YWD711

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED		
		155095 B. WING					03/22/2012	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER	L			OBSON RD			
HERITAC	GE PARK				VAYNE, IN 46805			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
F0514	483.75(I)(1)							
SS=D	RES							
		//PLETE/ACCURATE/ACCE						
	SSIBLE	manimetric aliminal managers						
		maintain clinical records on accordance with accepted						
		ndards and practices that are						
		ately documented; readily						
		systematically organized.						
	,	, ,						
		rd must contain sufficient						
		entify the resident; a record						
		assessments; the plan of						
		s provided; the results of any						
	State; and progre	reening conducted by the						
			F05	1.4	F514It is the practice of this		04/06/2012	
		ation, interviews and	103	14	provider to maintain clinical		04/00/2012	
	· ·	e facility failed to			recoreds on each resident in			
	document a med	ication as administered as			accordance with accepted professional standards and practices that are complete; accurately documented; readily			
	ordered on the M	Iedication Administration						
	Record. This de	ficiency affected 1 of 7						
	residents reviewe	ed for clinical records in						
	a sample of 7 (Re	esident G).			accessible; and systematically			
	w sumpre or / (re	osident e).			organized. However; based of			
	Findings include				the alleged deficient practice-	uie		
	Tillulligs illetude	•			implemented:What corrective			
	<b>.</b>				action(s) will be accomplished	for		
		ord was reviewed on			those residetns found to have			
		a.m., and indicated			been affected by the deficient			
	Resident G's diag	gnoses included, but were			practice:Resident GThe cerovi			
	not limited to, de	epression and			liquid has been D/C'd related t			
	hypertension.				no longer being indicated.How you identify other residents	WIII		
					having the potential to be affect	cted		
	The Physician's (	Order Sheet dated 3/1/12			by the same deficient practice			
	-	er dated 5/19/08 for			and what corrective action will	be		
					taken:No other residents were			
		used to treat or prevent			found to have been affected by	y		
		cy), give 5 milliliters (ml)			the alleged deficient practice			
	once a day.				Residents requiring medication	า		

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Event ID: YWD711

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED	
		155095	A. BUILDING  B. WING  03/22/2012			2012	
			b. Will		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	8			OBSON RD		
HERITAC	GF PARK				VAYNE, IN 46805		
						-	215
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	be administered have the		DATE
					potential to be affected by the		
	The March 2012				alleged deficient practice.The		
	Administration F	Record (MAR) indicated			Licensed Staff have been		
	the medication c	erovite liquid, give 5 ml			re-educated on medication		
	once daily, was i	not signed out as given			administration documentation		
	from 3/1 through	n 3/16/12.			expectations. Education inclu		
					but is not limited to initialing of		
	On 3/16/12 at 11	:45 a.m., LPN #1 was			medications when administere reading the MAR when passin		
		egard to the cerovite			medications and reviewing	9	
		igned out as given, and			documentation at the end of th	neir	
					shift for completeness.A returr	۱	
		d she worked Monday			demonstration for medication		
		nd had given the resident			administration/documentation		
		ication and not signed the			requirements has been		
	March 2012 MA	R. An observation with			completed with licensed staff.Education provided by the	_	
	LPN #1 of the ce	erovite medication was			Director of Nursing Services a		
	available in the f	Facility.			the SDC March 21-28, 2012.T		
					Unit Managers are responsible	e to	
	The Director of 1	Nursing Services (DNS)			ensure compliance.What		
		on 3/22/12 at 8:45 a.m.			measures will be put into place		
		weekend doses of the			what systemic changes you wi make to ensure that the deficie		
	-	ed out as given. The			practice does not recur:Reside		
	_	he had spoken to the			requiring medication be	,,,,,	
					administered havae the pitenti	al	
	•	LPN #4, and the nurse			to be affected by the alleged		
	_	sident the cerovite			deficient practice.The License		
		ot signed the March			Staff have been re-educated o	n	
		S further indicated			medication administration documentation expectations.		
	Resident G had b	been prescribed the			Education includes but is not		
	cerovite due to h	aving a tube feed in the			limited to initialing off medicati	ons	
	past.				when administered, reading th		
					MAR when passing medication		
	This federal tag	relates to complaints			and reviewing documentation	at	
	IN00105054 and	•			the end of their shift for		
	11100103037 and	11100103270.			completeness.A return demonstration for medication		
	2.1.50(a)(2)				administration/documentation		
	3.1-50(a)(2)						

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/17/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155095	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COMPLETED 03/22/2012			
	PROVIDER OR SUPPLIER GE PARK		STREET ADDRESS, CITY, STATE, ZIP CODE  2001 HOBSON RD  FORT WAYNE, IN 46805					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION			
				requirements has been completed with licensed staff.Education provided by Director of Nursing Services the SDC March 21-28, 2012 Unit Managers are responsi ensure compliance. How the corrective action(s) will be monitored to ensure the defi practice will not recur: A CQI monitoring tool titled "Medica Administration Documentation will be utilized every week x monthly x 3 and quarterly thereafter for 6 months. Data be submitted to the CQI Committee. If 95% threshold not met; an action plan will be developed. Non-compliance facillity procedure may result disciplinary action up to and including termination.	s and the ble to ticient ation on" 4, the will this be with thin			

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Event ID: YWD711

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